PRINTED: 09/14/2011 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES	OMB NO. 0938-				
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIM DDIG	00	COMPLETED		
		155784	A. BUILDING		08/24/2011		
			B. WING	ADDRESS OF STATE OF SORE			
NAME OF I	PROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP CODE			
MICHIAN		EHABILITATION CENTER		DOUGLAS ROAD WAKA, IN46545			
	·	ENABIENATION CENTER	IWIIOTIA				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE		
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
TAG F0000	This visit was for Complaint # INC Complaint # INC Federal/State de allegations are consumption of the second of t	00094821-Substantiated, ficiencies related to the ited at F-309. Ingust 23 and 24, 2011 1012329 1155784 201002500 RN TC	F0000	The preparation or execution this plan of correction does reconstitute admission or agreement by the provider of truth of the facts alleged or conclusions set forth on the statement of deficiencies. To plan of correction is prepared executed solely because it it requried by federal and states.	n of not f the he d and		
	Sample: 7 These state findi	ings are cited in					
	i i iicse state iiiidi	mgs are ched in	1	I	1		

 $LABORATORY\ DIRECTOR'S\ OR\ PROVIDER/SUPPLIER\ REPRESENTATIVE'S\ SIGNATURE$

accordance with 410 IAC 16.2.

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: BMO311 TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/24/2011	
	PROVIDER OR SUPPLIER	HABILITATION CENTER	142	EET ADDRESS, CITY, STATE, ZIP 20 E DOUGLAS ROAD SHAWAKA, IN46545	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) ompleted on August 29, lkner, RN	BE PERCEDED BY FULL PREFIX (EACH CORRECTION HOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) d on August 29,		(X5) COMPLETION DATE	
F0309 SS=G	must provide the reto attain or maintal physical, mental, a in accordance with assessment and physical metal, a in accordance with assessment and physical metal m	interview and riew, the filed to provide fary care to betic residents who filed a emic (low far) episode for to nursing	F0309	Resident #C no long the center. Resident negative outcomes this alleged deficier is currently being mand cares provided hypoglycemic episcone time review of cresidents in current has been completed blood glucose result 1st forward, and the been taken and door the medical recording resident condition. Ordered diabetic probeen reviewed to endirections are present staff to follow and dishould a resident end blood sugar. No have been re-education protocol, document requirements of act findings in the medical and what is expected.	nt #E had no as a result of nt practice and nonitored for should ode occur. A diabetic population d to review Its from August at actions have cumented in to reflect The physician otocol has nsure clear ent for nursing locuemtned experience a lursing staff ated on the diabetic ration tion and ical record,	09/14/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	(X2) MULTIPLE CONSTRUCTION 00			(X3) DATE SURVEY COMPLETED		
THIND I LIMIT	or connection	155784	A. BUI B. WIN	LDING		08/24/2		
NAME OF B	AD OUTDED ON GUIDDING		B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
	PROVIDER OR SUPPLIER			1	DOUGLAS ROAD			
	IA HEALTH AND RE	EHABILITATION CENTER		MISHA	WAKA, IN46545			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
	becoming			follow up actions should they be necessary. It is the responsibility				
	non-responsive and				of the licensed Nurse to follo physician ordered diabitic	w the		
	_	hospitalization.			protocol. The Unit Manger/designee will be			
	This defic	ient practice			betic			
	affected 2	of 7 residents			flow records and results of accucheck reading daily for 14 days, three times a week for 8 weeks, weekly for 8 weeks, and			
	reviewed	with diabetes			then monthly thereafter for current population. Any ider			
	in a sampl	le of 7.			non-compliance will result in 1:1 re-education, with disciliplinary			
	Findings i	nclude:	action to follow as necessary to and including discharge fr employment. The Administrator/Designee will I responsible to review schedu					
	1. Resider	nt #C's clinical			audits weekly. Audits will be submitted monthly for 6 mon and quarterly thereafter at ce	ths		
	record wa	s reviewed on			Quality Performance Improvement Committee.			
	8/23/11 at	3:45 P.M.,			Identified trends will be addressed as appropriate the	rough		
		ited diagnoses			1:1 re-education and the appropriate disciplinary proc	ess		
		t limited to,			per policy.			
	fractured 1	broken neck,						
	fractured 1	nose, and						
	diabetes n	nellitus.						
	Resident #	#C's clinical						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155784		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 08/24/2	ETED	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	p. w.r.	STREET A 1420 E	ADDRESS, CITY, STATE, ZIP CODE DOUGLAS ROAD WAKA, IN46545	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	record inc	luded a					
	"History and Physical						
	Final Report" from his						
	hospitaliza	ation prior to					
	his 6/03/1	1 admission to					
	the facility	y. It was dated					
	4/22/11, p						
	5/26/11, and indicated,						
	"We wil	l monitor his					
	blood sug	ars, adjust his					
	medication	ns. These are					
	uncontroll	led at this point					
	due to his	use of					
	steroids. T	This should					
	improve a	s he weans off					
	his steroid	ls" A					
	hospital li	st of discharge					
	medication	ns indicated					
	Resident #	C did not					
	continue t	he steroid					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURV	
ANDILAN	OF CORRECTION	155784	A. BUII B. WIN		00	08/24/2011	
NAME OF F	PROVIDER OR SUPPLIER		B. WIIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
MICHIAN	IA HEALTH AND RE	EHABILITATION CENTER		1	DOUGLAS ROAD WAKA, IN46545		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	re CO	OMPLETION DATE
	medicatio	n upon					
	admission to the long						
	term care	facility.					
	A Physicia	an's Order,					
	dated 6/03/11, indicated,						
	"Blood sugar checks						
	before me	als and at HS					
	(bedtime)	."					
	Review of	f Resident #C's					
	Medicatio	n					
	Administr	ration Record					
	(MAR), d	ated 7/01/11					
	through 7	/31/11,					
	indicated	low blood					
	sugar reac	lings as					
	follows: b	lood sugar of					
	66 at 11 A	.M. and 51 at					
	9:00 P.M.	on 7/10/11;					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155784			ULTIPLE CO LDING	ONSTRUCTION 00	(X3) DATE : COMPL 08/24/2	ETED	
		100784	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	08/24/2	011
NAME OF P	PROVIDER OR SUPPLIER			1	DOUGLAS ROAD		
MICHIAN	IA HEALTH AND RE	HABILITATION CENTER		MISHA\	WAKA, IN46545		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛΤΕ	DATE
	blood sug	ar reading of					
	51 at 9:00	P.M. on					
	7/13/11, and blood sugar						
	reading of 60 at 9:00						
	P.M. on 7/18/11.						
	Nurse's N						
	7/13/11 at	8:00 P.M.,					
	indicated,	"Res (resident)					
	was noted	sweating. BS					
	was 41. G	ave 120 cc of					
	orange jui	ce, repeated					
	BS after 2	0 min.					
	(minutes).	BS level was					
	54. Re-off	fered more					
	OJfaxed	to Dr. (Name)					
	will keep	monitoring."					
	A Dieticia	n's Progress					
	Note, date	ed 7/14/11 at					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 08/24/2	ETED	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	P. WII.	STREET A	DOUGLAS ROAD NAKA, IN46545		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	12:05 P.M	I., indicated,					
	"Resident	reported to					
	have hypo	glycemic (low					
	blood sug	ar) episode. BS					
	checked 9	P.M. 7/13/11					
	with resul	t 51. Resident					
	receives C						
	Januvia, Metformin,						
	Levemir,	and Novolog in					
	the A.M. 1	Residents (sic)					
	receives N	Meftormin and					
	Novolog b	pefore					
	supperN	ID notified.					
	Orange jc	(juice) 120 cc					
	given duri	ing					
	hypoglyce	emic episode.					
	Repeat BS	S with result					
	54, more 6	orange jc					
	offered. R	epeat BS with					
	result 78.	Review of last					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155784		(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY MPLETED 1/2011	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	1420 E	ADDRESS, CITY, STATE, ZIP CO DOUGLAS ROAD WAKA, IN46545	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	7 days HS	snack shows				
	variable in	ntake"				
	Nurse's N 7/28/11, in following "In W/C (has pover BS (blood Given OJ & went to therapy); -Called to Pt (patient (sweaty) a non-respo Given inst cc (cubic Glucagon	otes, dated ndicated the : 4:00 P.M wheel chair) ty of thoughts. l sugar) 65. (orange juice) PT (physical 6:15 P.M. dining room. t) diaphoretic				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155784		A. BUILDING	00	COM	TE SURVEY MPLETED 4/2011
		STREE* 1420	E DOUGLAS ROAD	CODE	
(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
68/31. Sti	ll not				
responsive	e. Able to				
follow co	mmand; 7:00				
P.MCall	ed Dr. (Name)				
-Sent to H	lospital; 7:30				
P.M(Am	bulance				
Service) h	ere for pickup				
remains u	nresponsive				
B/P 67/35	P (pulse)-52.				
Sitting up	right. Can				
follow con	mmands.				
for 7/28/1 "4:00 P.M (insulin) h Unable to verbalize. went to P	1 indicated: INovolog neld for BS 65Given OJ & Γ with				
	PROVIDER OR SUPPLIER SUMMARY'S (EACH DEFICIEN REGULATORY OR 68/31. Stiresponsive follow corp. MCall-Sent to H. P.M(Am. Service) has remains upper follow corp. Late entry for 7/28/1 "4:00 P.M. (insulin) has upper follow corp. Unable to verbalize. went to P. M. went to P. W. went to P. M. went to P. M. went to P. W. went to P. M. went to P. M. went to P. W. went	OF CORRECTION IDENTIFICATION NUMBER:	DENTIFICATION NUMBER: 155784 DENTIFICATION NUMBER: 1420 MISH DENTIFICATION NUMBER: 1420 DENTIFICATION NUMBER: 1420	DENTIFICATION NUMBER: 155784 DENTIFICATION NUMBER: 1420 E DOUGLAS ROAD MISHAWAKA, IN46545 DENTIFICATION NUMBER: 1420 E DOUGLAS ROAD MISHAWAKA, IN46545 DENTIFICATION NUMBER: 150 PREPRINCE NOT NOT NUMBER SILAN OF CRASS-REFERENCE NOT	STREET ADDRESS. CITY, STATE, ZIP CODE STATE, ZIP C

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 08/24/20	ETED	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	р. үн	1420 E	NAKA, IN46545	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	juice; 6:15	5 P.MCalled					
	to dining room stating						
	"Somethin	ng's wrong he's					
	non-respo	nsive." Pt.					
	found with	h head down in					
	W/C very diaphoretic.						
	Responds to command.						
	Able to so	ueeze my					
	hand. Una	ble to speek					
	(sic) or sw	vallow is					
	drooling-t	aken to nsg					
	(nursing)	station & BS					
	check was	38. Given					
	Given Glu	icagon 1 cc IM					
	(intramuse	cular) L Ant					
	(left anter	ior) thigh; 6:30					
	P.MBS	65-Able to					
	swallow.	Insta-glucose.					
	Still unab	le to speek					
	(sic). Head	d down but					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155784		(X2) MULTIPLE A. BUILDING B. WING	00	COM	TE SURVEY MPLETED 1/2011	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	1420	T ADDRESS, CITY, STATE, ZIP CO E DOUGLAS ROAD AWAKA, IN46545	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	sitting upr	right in w/c;				
	6:45 P.MBS 116 A					
	little more	e alert but still				
	not norma	ıl. B/P 68/31, P				
	48Able	to follow				
	command	'lifts hand;'				
	7:00 P.M.	-B/P 65/27, P				
	52. Dr. (Name)					
	paged-Ser	nt pt. to				
	Hospital;	7:30 P.M				
	(Ambulan	ce Service)				
	here for p	t. pickup.				
	Remains 1	non-verbal. B/P				
	64/27, P 4	8" Nurse's				
	Notes lack	ked				
	document	ation to				
	indicate th	ne nurse				
	followed-	up and				
	monitored	l resident #C's				
	response t	to the orange				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155784		A. BUI	LDING	NSTRUCTION 00	(X3) DATE : COMPL 08/24/2	ETED	
	PROVIDER OR SUPPLIER	HABILITATION CENTER	B. WIN	STREET A 1420 E	ADDRESS, CITY, STATE, ZIP CODE DOUGLAS ROAD WAKA, IN46545	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	juice adm	inistered at					
	4:00 P.M.	and the affect					
	physical activity had on						
	his already	y low blood					
	sugar.						
	Resident #						
	Medicatio	n					
	Administr	ration Record					
	(MAR), d	ated 7/01/11					
	through 7/	/31/11,					
	indicated,	"If BS is less					
	then 60 in	itiate					
	protocol	(step one): if					
	alert, resp	onsive and able					
	to swallov	v: give 120 cc					
	(cubic cen	timeters) (4					
	oz) of ora	nge juice or 1					
	tube in (si	c) instaglucose					
	gel orally.	Continue to					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	COM	TE SURVEY MPLETED 4/2011	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	1420 E	CADDRESS, CITY, STATE, ZIP CO E DOUGLAS ROAD AWAKA, IN46545	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	monitor &	repeat blood				
	sugar in 1	5 to 20				
	minutes. (step two): If				
	BS rises, t	follow with a				
	protein sn	ack. If unable				
	to raise B	S repeat 120 cc				
	of juice &	recheck BS in				
	another 15	5-20 minutes.				
	If unable 1	to raise BS				
	notify MD) (medical				
	doctor). D	ocument all				
	findings &	actions"				
	During tel	ephone				
	interview	with Resident				
	#C's spou	se on 8/23/11				
	at 12:45 P	M., she				
	indicated	the above				
	incident o	ccurred on				
	7/29/11, n	ot 7/28/11 as				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE: COMPL 08/24/2	ETED	
NAME OF P	ROVIDER OR SUPPLIEF	. R	•		ADDRESS, CITY, STATE, ZIP CODE DOUGLAS ROAD		
MICHIAN	IA HEALTH AND RE	EHABILITATION CENTER			WAKA, IN46545		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	indicated	in the Nurse's					
	Note. She	further					
	indicated	she began					
	bringing i	n cookies and					
	fruit for R	Resident #C and					
	insisted he	e eat them in					
	the evening because she						
	was conce	erned he might					
	experienc	e episodes of					
	low blood	l sugar. "I					
	complaine	ed numerous					
	times to the	ne nursing staff.					
	RN #3 too	ok my concerns					
	to the Dir	ector of					
	Nursing, l	out nothing was					
	done abou	ıt it. The day					
	before (Re	esident #C)					
	went into	the coma, my					
	two sons i	met with the					
	Administr	rator and the					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE S COMPL 08/24/2	ETED	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	D. WIIV	STREET A	ADDRESS, CITY, STATE, ZIP CODE DOUGLAS ROAD WAKA, IN46545		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	Director o	of Nursing and					
	they revie	wed my					
	husband's	blood sugar.					
	The Admi	nistrator said,					
	'Well, yea	h, it did go					
	down to 5	1, but we did					
	get it up.'	They were					
	giving hin	n four doses of					
	insulin a c	lay, but he was					
	no longer	getting the					
	steroid. Tl	he reason he					
	was on ins	sulin was					
	because th	ne steroid					
	elevated h	is blood					
	sugars. I v	vent to therapy					
	with him ((7/29/11) and					
	he was ha	ving a hard					
	time putti	ng one foot in					
	front of th	e other. He					
	wanted to	go lie down.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/24/2011			
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS ROAD MISHAWAKA, IN46545					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	(Resident	#C) was						
	unrespons	sive when he						
	arrived at	the Emergency						
	Room."							
	The MAR	, dated 7/01/11						
	through 7	/31/11,						
	indicated	resident #C						
	received t	he following						
	medicatio	ns to control						
	and lower	his blood						
	sugar: Lev	vemir (long						
	acting ins	ulin)12 u						
	(units) SQ)						
	(subcutan	eous) (beneath						
		every morning						
	before bre	eakfast (8:00						
		ovolog (rapid						
		ulin) 5 u SQ in						
	the morni	,						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		(X2) MI A. BUII B. WIN	LDING	00	(X3) DATE COMPI 08/24/2	LETED	
	PROVIDER OR SUPPLIER	HABILITATION CENTER	•	1420 E	ADDRESS, CITY, STATE, ZIP CODE DOUGLAS ROAD WAKA, IN46545	'	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
		(8:00 A.M.),					
	Actos 45 mg.						
	(milligran	n) orally at 8:00					
	A.M., Gli	mepiride 6 mg.					
	orally at 8	,					
	Januvia 10	00 mg. orally at					
	8:00 A.M.	., Metformin					
	1,000 mg.	orally with					
	breakfast	(8:00 A.M.)					
	and dinner	r (5:00 P.M.),					
	Novolog (rapid acting					
	insulin) 7	u SQ with					
	supper (5:	00 P.M.).					
	A pharma	cy "Potential					
	Drug Inter	raction," dated					
	6/3/11, inc	dicated,					
	"Drug Dispensed:						
	Aspirin E	C (enteric					
	coated) 32	25 Mg. Tablet					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155784		(X2) MULTIPLE (A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/24/2011	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	STREE 1420	T ADDRESS, CITY, STATE, ZIP CODE E DOUGLAS ROAD AWAKA, IN46545	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODECTION OF THE APPROPRIES OF THE A	D BE COMPLETION
	Interacts v	with:			
	Glimepiri	de 2 Mg.			
	Tablet (Re	esident #C was			
	receiving	6			
	Mg.)Pat	ient			
	Managem	ent:			
	Hypoglyc	emic (a state of			
	low blood	sugar level)			
	signs and	blood glucose			
	levels sho	uld be			
	monitored	l. Adjust the			
	antidiabet	ic dose as			
	needed	"			
	Resident #	C's "Resident"			
	Transfer F	Form," dated			
	7/29/11, ii	ndicated, "Sent			
	to: (Name	of			
	Hospital).	Reason for			
	transfer: E	BS @ 6:15			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUIL		INSTRUCTION 00	(X3) DATE S COMPL		
		155784	B. WING	G		08/24/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE DOUGLAS ROAD		
MICHIAN	IA HEALTH AND RE	EHABILITATION CENTER		MISHA\	NAKA, IN46545		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE.	DATE
	(P.M.) wa	s 38BP					
	72/34"						
	Emergenc	y Department					
	Physician	Notes, dated					
	7/30/11 at	12:09 A.M.,					
	indicated, "History of						
	present ill	ness: the					
	patient pro	esents with					
	hypoglyce	emia (low					
	blood sug	ar)EMS					
	(Emergen	cy Medical					
	Staff) had	to administer					
	1 amp (an	npoule) d50					
	(dextrose)	during					
	transport	.Notes:					
	Hypoglyc	emia. Given					
	multiple n	nedications					
	with prolo	onged 1/2 life					
	and repeat	t hypoglycemic					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

BMO311 Facility ID:

012329

If continuation sheet

Page 19 of 26

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784		(X2) MULTIPLE CO A. BUILDING B. WING	00		E SURVEY PLETED /2011	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	1420 E	ADDRESS, CITY, STATE, ZIP COD E DOUGLAS ROAD WAKA, IN46545	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	episodes,	will need admit				
	for further	r checks.				
	Started IV	(intra-venous)				
	dextrose	"				
	2. Resider	nt #E's clinical				
	record wa	s reviewed on				
	8/23/11 at	2:00 P.M.,				
	and indica	ated diagnoses				
	of, but no	t limited to,				
	chronic of	ostructive				
	pulmonar	y disease,				
	thyroid di	sease, and				
	diabetes n	nellitus.				
	During in:	itial tour of the				
	facility on	8/23/11 at				
	9:15 A.M	., while				
		nied by RN #2,				
	*	ted Resident				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155784		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	COM	(X3) DATE SURVEY COMPLETED 08/24/2011			
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS ROAD MISHAWAKA, IN46545					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	#E was al	ert and oriented						
	and interv	riewable.						
	Resident #	#E's most						
	recent qua	arterly MDS						
	(Minimun	n Data Set)						
	Assessme	nt, dated						
	7/22/11, ii	ndicated her						
	cognicity score as 15 (no							
	cognitive	impairment).						
	Resident #E's Medication Administration Record (MAR), dated 4/01/11 through 4/30/11, indicated, "If blood sugar os (sic) less then 60 initiate protocol (step one): if alert, responsive and able to							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE S' COMPLE 08/24/20	ETED		
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS ROAD MISHAWAKA, IN46545					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛΤΕ	(X5) COMPLETION DATE	
	swallow:	give 120 cc						
	(cubic centimeters) (4							
	oz) of ora	nge juice or 1						
	tube in (si	c) instaglucose						
	gel orally.	Continue to						
	monitor a	nd repeat blood						
	sugar in 1	5 to 20						
	minutes. (step two): If						
	blood sug	ar rises, follow						
	with a pro	tein snack. If						
	unable to	raise blood						
	sugar repe	eat 120 cc of						
	juice and	recheck blood						
	sugar in a	nother 15-20						
	minutes. I	f unable to						
	raise bloo	d sugar notify						
	MD (med	ical doctor).						
	Documen	t all findings						
	and action	s" It further						
	indicated	her blood sugar						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ĺ	ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
		155784	B. WIN	IG		08/24/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE DOUGLAS ROAD		
MICHIAN	IA HEALTH AND RE	EHABILITATION CENTER		1	WAKA, IN46545		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)	_	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	levels wer	re to be					
	checked a	t 4:00 A.M.,					
	7:00 A.M., 11:30 A.M.,						
	5:00 P.M.	and 9:00 P.M.					
	Review of	f Resident #E's					
	MAR's indicated the						
	following	: 4/02/11 at					
	11:30 A.M	I. BS (blood					
	sugar)=48	, 4/06/11 at					
	7:00 A.M.	BS = 40,					
	4/20/11 at	11:30 A.M.					
	BS = 60, 4	4/25/11 at 4:00					
	A.M. BS =	=48, 6/07/11 at					
	4:00 A.M.	BS = 60,					
	6/15/11 at	11:30 A.M.					
	$BS = 55, \epsilon$	6/23/11 at					
	11:30 A.M	I. BS = 54, and					
	7/18/11 at	7:00 A.M. BS					
	= 54. Furt	her review of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING			(X3) DATE SURVEY COMPLETED - 08/24/2011		
	PROVIDER OR SUPPLIER	HABILITATION CENTER	B. WIN	STREET A 1420 E	ADDRESS, CITY, STATE, ZIP CODE DOUGLAS ROAD NAKA, IN46545		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	the MAR	and Resident					
	#E's clinic	eal record					
	lacked documentation to						
	indicate th	ne					
	intervention	ons were					
	implemen	ted.					
	RN #2 inc	licated in an					
	interview	on 8/23/11 at					
	3:10 P.M.	, the					
	document						
	nursing in	tervention that					
		mented would					
	•	d on the MAR					
	under the	blood sugar					
		'The nurse					
	•	ve documented					
		n't follow the					
		s protocol."					
		5 proto c or.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION		IXI) PROVIDER/SUPPLIER/CLIA		ULTIPLE CO LDING	00		COMPL	ETED
155784		B. WING				08/24/2011		
NAME OF PROVIDER OR SUPPLIER				1	DOUGLAS ROAL			
MICHIANA HEALTH AND REHABILITATION CENTER				1	NAKA, IN46545			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID PROVIDER'S PLAN OF C				(X5) COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG CROSS-REFERENCED TO THE AP			E	DATE
	During int	terview with						
	Resident #E on 8/23/11							
	at 3:15 P.I	M., she						
	indicated her blood sugar							
		e dropped too						
	low severa	al times. "I can						
	tell when	it is too low."						
	She furthe	er indicated the						
	nurse wou	ıld give her a						
	glass of or	range juice to						
	drink in a	n attempt to						
	bring the l	blood sugar up.						
	When que	eried if the						
	nurse rech	necks her blood						
	sugar leve	el again in						
	15-20 min	nutes, Resident						
	#E indicat	ted her blood						
	sugar leve	els were not						
	checked a	gain until meal						
	time.							
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	BMO311	Facility 1	ID: 012329	If continuation sh	neet Pa	ge 25 of 26

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155784		(X2) MULTIPLE CC A. BUILDING B. WING	00	— COM 08/24	(X3) DATE SURVEY COMPLETED 08/24/2011		
	PROVIDER OR SUPPLIE NA HEALTH AND R	R EHABILITATION CENTER	1420 E	ADDRESS, CITY, STATE, ZIP CO DOUGLAS ROAD WAKA, IN46545	ODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	OBE COMPLETION	
	This Federate to complain IN000948 3.1-37(a)						